

Please read the **MassHealth and You** guide carefully before you fill out this supplement. If you are applying for MassHealth long-term-care services, fill out this supplement (blue form) and send it to the MassHealth Enrollment Center listed on the letter that came with this supplement.

Please print clearly. Answer all questions and fill out all sections. If you need more space to finish any section, please use a separate sheet of paper, and attach it to this supplement.

Applicant/Member Information

Last name	First name	MI	Social security number
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▶ Do you have to pay guardianship expenses for a court-appointed guardian?..... ☐ yes ☐ no

Living expenses of the spouse and family members living at home

Your spouse living at home may be able to keep some of your income. Fill out the following information about your spouse's current living expenses.

If you do not have a spouse, go to the next section (Long-Term-Care Insurance).

✉ **Send proof** of your spouse's current living expenses.

▶ 1. How much does your spouse pay each month for:

Rent?	Mortgage (principal and interest)?	Homeowner's/ tenant's insurance?	Real estate taxes?	Required maintenance charge for a condo or co-op?	Room and board for assisted living?
\$	\$	\$	\$	\$	\$

▶ 2. Does your spouse pay for heat? ☐ yes ☐ no

▶ 3. Does your spouse pay for utilities? ☐ yes ☐ no

▶ 4. Is a child, parent, brother, and/or sister living with your spouse? ☐ yes ☐ no

If yes, fill out this section.

If no, go to the next section (Long-Term-Care Insurance).

✉ **Send proof** of their monthly income before deductions.

A deduction may be allowed for their maintenance needs. These persons must be related to you or your spouse, and one of you must claim them as dependents on your federal income tax return.

Name	Social security number	Relationship	Date of birth	Monthly income before deductions
			/ /	\$
			/ /	\$

Long-Term-Care Insurance

▶ Do you or your spouse have long-term-care insurance? ☐ yes ☐ no

If yes, fill out this section.

If no, go to the next section (Real Estate).

✉ **Send a copy** of the policy.

Company name/Policy number	Policyholder name	Effective date	Premium amount
		/ /	\$
		/ /	\$

Real Estate

The answers to the following questions will be used to decide if: (1) your real estate will be counted as an asset; or (2) a lien will be placed against your real estate. Your home is a noncountable asset if you intend to return to it. Your home may be subject to a lien. However, if you own long-term-care insurance that meets certain requirements when you enter a long-term-care facility, your home is noncountable regardless of your intent to return.

1. Do you or your spouse own or have a legal interest in your home, including a life estate? ☐ yes ☐ no

If yes, fill out the following information and answer questions 2 through 4.

If no, answer question 4 only.

Name and address of person(s) on ownership papers	Description and address of property location	Fair-market value
		\$
		\$

2. Do you have a	<i>If you answered yes,</i> fill out this column and the next.	Is this person living in your home?
spouse? <input type="checkbox"/> yes <input type="checkbox"/> no	Name:	<input type="checkbox"/> yes <input type="checkbox"/> no
permanently and totally disabled or blind child? <input type="checkbox"/> yes <input type="checkbox"/> no	Name:	<input type="checkbox"/> yes <input type="checkbox"/> no
child under 21 years of age? <input type="checkbox"/> yes <input type="checkbox"/> no	Name: Date of birth: / /	<input type="checkbox"/> yes <input type="checkbox"/> no
brother or sister with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? <input type="checkbox"/> yes <input type="checkbox"/> no	Name:	<input type="checkbox"/> yes <input type="checkbox"/> no
son or daughter who has lived in the home for at least the last two years before your admission to the medical institution and has provided care to you that allowed you to live in the home? <input type="checkbox"/> yes <input type="checkbox"/> no	Name:	<input type="checkbox"/> yes <input type="checkbox"/> no
dependent relative? <input type="checkbox"/> yes <input type="checkbox"/> no	Name: Describe the relationship and the nature of the dependency:	<input type="checkbox"/> yes <input type="checkbox"/> no

3. Do you intend to return to your home? ☐ yes ☐ no

4. Do you or your spouse own or have a legal interest in other real estate not listed in #1 above? ☐ yes ☐ no

If yes, please describe the property and list its address below.

Resource Transfers (resources include both income and assets)

- 1. In the last 36 months:
- a. Did you, your spouse, or someone on your behalf transfer income or the right to income? ☐ yes ☐ no
 - b. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real estate? ☐ yes ☐ no
 - c. Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate? ☐ yes ☐ no
 - d. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own? ☐ yes ☐ no
 - e. Did you, your spouse, or someone on your behalf give anyone a mortgage or promissory note on property you own? ☐ yes ☐ no
- 2. In the last 60 months, has any property available or belonging to you or your spouse been transferred into or out of a trust of which you or your spouse are or had been a beneficiary, trustee, or grantor? ☐ yes ☐ no

If you answered yes to any of the questions above, you must fill out the following.

Description of asset/income	Dates of transfer	Transferred to whom	Relationship to you or your spouse	Amount of transfer
	/ /			\$
	/ /			\$
	/ /			\$

- 3. Have you, your spouse, or someone acting on your behalf given a deposit to any health-care or residential facility, like an assisted-living facility? ☐ yes ☐ no
- If **yes**, give us the name and address of the facility, and the amount of the deposit, and answer the following questions.

Name of facility	Address of facility	Amount
		\$
<p>a. Does the facility still have the deposit? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>b. Did the facility return the deposit? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>If yes, give us the name and address of the person who got the deposit from the facility.</p>		
Name	Address	

Tax Returns

- Did you or your spouse file U.S. income tax returns in the last two years? ☐ yes ☐ no

☒ **If yes**, you must **send copies** of these returns. If you did not keep copies of your tax returns for the last two years, **you must send a filled-out and signed Form 4506 to the Internal Revenue Service.** Form 4506 is included as part of the Long-Term-Care Supplement if you need to use it.

I certify, under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge. I understand that this information will be used to decide if I can get or continue to get MassHealth payment of long-term-care services. I also understand that I must give proof of the information given on this form and report any changes in this information within 10 days of the change.

If you are acting on behalf of someone in filling out this form, a MassHealth Eligibility Representative Designation Form must also be filled out and sent back with this form. Your signature on this form as an eligibility representative certifies that the information on this form is correct and complete to the best of your knowledge.

X _____
Signature of applicant/member or eligibility representative

Date

X _____
Signature of applicant's/member's spouse

Date

